OLYMPIA ORTHOPAEDIC ASSOCIATES

SHOULDER / ARM HISTORY FORM

Patient Name: _____ **Date:**_____

1. Who referred you for this problem? _____
2. Nature of your shoulder/arm problem. (be specific as you can) _____

   _____ Right or Left
3. How long have you had this problem?_____
4. Was there a specific injury? Yes / No. If yes:

   How did the injury occur? _____

   When was the injury? _____

   Where did it occur? Home Work Sports Auto Accident Other _____
5. Is the problem work related? Yes / No If yes, has an L & I claim been filed? Yes / No

   Are you still working? Yes / No Light duty or Regular duty? Full time or Part time?

   If no, when did you last work? _____
6. Current Symptoms:

   Pain? Yes / No Location _____

   Severity: 1 2 3 4 5 6 7 8 9 10

   Mild Moderate Severe

   Circle what aggravates pain.

   Reaching overhead Behind back Throwing Pushing/ Pulling Lifting

   What relieves pain? _____

   Associated Symptoms

   Pain at night? Yes / No Numbness in the arm or hand? Yes / No

   Swelling? Yes / No Instability? Yes / No A History of dislocations? Yes / No

   Catching or Grinding sensations? Yes / No Locking sensation? Yes / No
7. What treatment have you tried? _____

   Ice? Yes / No Heat? Yes / No Tylenol? Yes / No

   Anti-inflammatories? Yes / No Which ones?_____

   Home Exercises? Yes / No Physical Therapy? Yes / No

   Sling? Yes / No Other_____
8. Have you had x-rays? Yes / No Where? _____ When? _____

   Other studies? Yes / No (CT scans/ MRI) Where? _____ When? _____
9. What activities/ exercises do you regularly participate in? _____

   Are you still able to participate? Yes / No